TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AHMED KHALIFA, MD

Respondent Name
TRAVELERS CASUALTY & SURETY COMPANY

MFDR Tracking Number
M4-18-0456-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
October 23, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has reduced this claim inappropriately and not in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $122.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the Maximum Allowable Reimbursement for the services in dispute and contends it was calculated correctly."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 12, 2016	Procedure Code 27096-50	$122.58	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 300 – AN ALLOWANCE HAS BEEN MADE FOR A BILATERAL PROCEDURE.
   - 836 – REIMBURSEMENT IS BASED ON THE APPLICABLE REIMBURSEMENT FEE SCHEDULE.
   - 947 – UPHELD. NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards payment of medical services with reimbursement subject to the division's *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, which requires that to determine the maximum allowable reimbursement (MAR), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule. Rule §134.203(c) specifies that:

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83.

(2) The conversion factors listed in paragraph (1) . . . shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors.

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the division conversion factor. The applicable division conversion factor for calendar year 2016 is $56.82.

Reimbursement is calculated as follows:

- Procedure code 27096, December 12, 2016, is a professional service paid per Rule §134.203(c). The provider billed this code with modifier 50, indicating bilateral service. Review of the submitted information finds this modifier is supported; reimbursement is thus adjusted by 150% of the fee for one unit. For this code, the relative value (RVU) for work of 1.48 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 1.50812. The practice expense (PE) RVU of 2.98 multiplied by the PE GPCI of 1.006 is 2.99788. The malpractice RVU of 0.13 multiplied by the malpractice GPCI of 0.955 is 0.12415. The sum of 4.63015 is multiplied by the division conversion factor of $56.82 for a MAR of $263.09. This amount is multiplied by the 150% bilateral procedure adjustment for a total of $394.64.

The division notes that the health care provider billed procedure code 27096 with modifier 50 indicating a bilateral procedure. CPT code 27096 denotes an injection of anesthetic/steroid into the sacroiliac joint, with image guidance. This procedure includes any arthrography, if performed. The division notes there are only two sacroiliac joints—one on each side of the body. The provider billed two units in addition to the 50 modifier. The provider may bill two units or use bilateral modifier (50)—but not both.

If the procedure is performed bilaterally, and modifier 50 is supported, then the adjustment for a bilateral procedure is 150% of the fee for a single unit.

If instead the provider bills 2 units, this procedure has a Medicare Multiple Procedure Policy Indicator of "2," indicating that standard payment adjustment rules for multiple procedures apply. The first unit of the highest-ranking procedure is paid at 100%. Each subsequent unit or procedure (if supported) is paid at 50%. Payment is then based on the lower of the actual charge, or the fee schedule amount reduced by the appropriate percentage.

In either case—whether billed with a 50 modifier or as 2 units—the maximum allowable reimbursement is 150% of the fee for a single procedure.

The total allowable reimbursement for the services in this dispute is $394.64. The insurance carrier has paid $394.64, leaving an amount due to the requestor of $0.00.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 21, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.